Discovery Acupuncture & Chinese Medicine

Confidential Health History Form

Name: _____ Date of Birth: _____
DD-MMM-YYYY
Gender: _____ Height: _____ Weight: _____ (approx.)
Email address:_____
Address: _____ Postal Code: _____
Cell number: _____ Alternate number: _____
Occupation: _____
Who referred you? _____
Emergency contact: _____ relationship: _____
Emergency contact cell number: _____

Main symptom: _____
Date main symptom started:_____
Have you seen your GP for this main symptom? Y/N date: _____
List any current treatments for main symptom: _____
_____
List any previous treatments for main symptom: _____
_____
Other symptoms of concern (feel free to list)_____
_____
_____
List all medications you are currently taking: _____
_____
List any supplements you are currently taking: _____
_____
List any surgeries, car accidents, or injuries: _____
_____
_____
List any allergies: _____
List any food sensitivities: _____
_____
Do you have a clotting or bleeding disorder? _____
Do you have a blood-borne disease? _____ Hepatitis? _____ HIV? _____
Do you have a pacemaker? _____

Mark any Personal or Family history with any of the following conditions: (mark P or F)

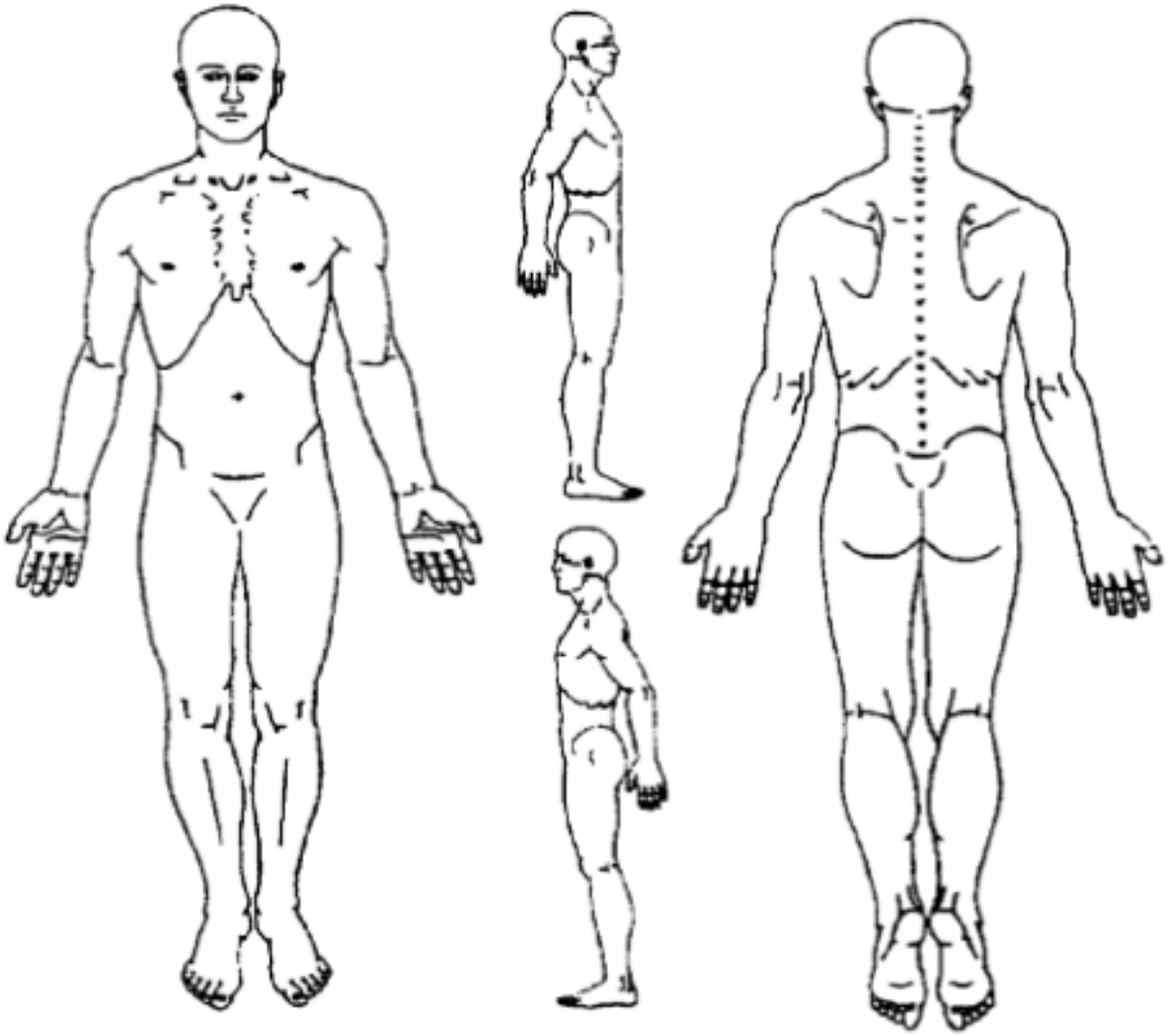
Allergies	Concussion	High Blood Pressure	Parkinson's
ADD/ADHD	Diabetes	Hypo/Hyperthyroidism	Respiratory Disease
ALS	Epilepsy	Multiple Sclerosis	Staph/Strep Infections
Cancer	Heart Disease	Osteoporosis	Stroke

Do you smoke? _____ If yes, for how long? _____
If you smoked in the past, when did you quit? _____
How often do you drink alcohol? _____
How often do you drink coffee? _____

If you are currently in pain, please check off the types of pain that you typically feel and rank the severity of each type out of 10 (10 being the worst):
achy___ numbness____ pins and needles___ burning___ stabbing_____ other ____

Draw the location of your pain on the figures below using the following symbols:

Ache	Numbness	Pins and Needles	Burning	Stabbing	Other
^^^^^	OOOOO	. . . . .	= = = = =	/ / / / / /	XXXX



Pain Frequency: constant_____ intermittent_____ daytime_____ night_____
Does the pain disturb your sleep? _____
What makes the pain better? _____ worse?_____
List which activities can you no longer do due to the pain:
_____
_____